APPENDIX
Additional Guidelines Or Suggested Practices

PART III: COMPLAINTS AND REPORTS

ISSUES TO CONSIDER WHEN IDENTIFYING A CARETAKER

In determining whether a person is a caretaker, it may be helpful to consider several questions:

What is the person's relationship with the child?
What is that person's role or function toward the child?
Was the primary responsibility of the person toward the child one of supervision and providing care, or was the person providing a professional or expert service?
How do the child and the child's usual caretaker view this relationship and role?
How does the community view this relationship and role?
Have the parents or other person specifically delegated formally or informally the caretaking role for this person?

Practice in some communities has been to exclude some types of persons as caretakers based on the needs of the children, the abilities of families to protect them, and other remedies in place such as a professional licensing board. Some exclusions have included sheriffs, police, doctors, dentists and psychotherapists. Non-public school teachers, coaches, music teachers, etc., have also been unofficially and routinely excluded from the definition of caretaker in some locales.

Frequently there are concerns when the alleged abuser is a minor. The following considerations may guide the decisions regarding a minor as caretaker and alleged abuser:

1. Was it appropriate for the juvenile to have been put in a caretaking role? Was the supervision plan appropriate?
2. Was the alleged abuse by the minor indicative of his/her own abuse? (i.e. sexual knowledge or behavior that is age inappropriate)
3. What is the age difference between the alleged abuser and the victim; was this peer interaction?
4. What is the minor's understanding of what he did; does he realize how inappropriate it was?
5. Is this acting out rather than abusive behavior?

Special consideration must be given to the needs of minor caretakers who are abusive. The report may be Unfounded in relation to the minor as the abuser, because it is determined that the minor was inappropriately placed in a caretaking role. However, the behaviors of the minor may indicate a need for services.

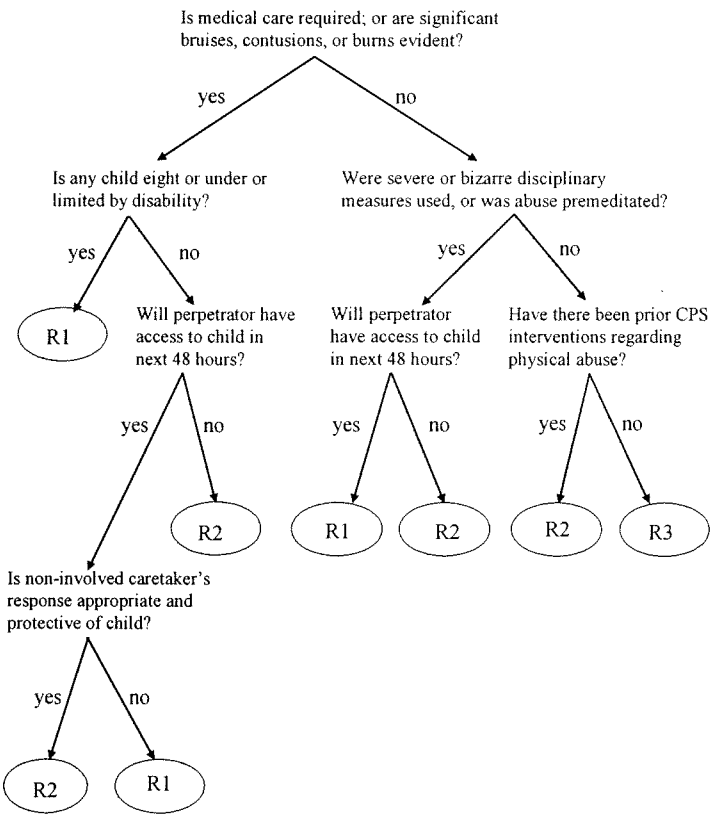
APPENDIX
Additional Guidelines Or Suggested Practices

Each local department maintains the discretion to validate reports of child abuse and neglect.

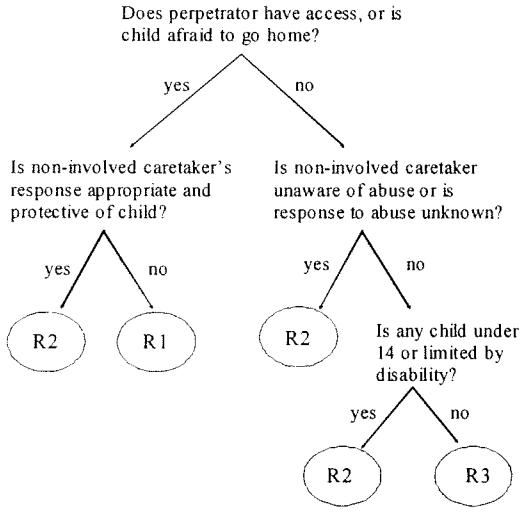
RESPONSE PRIORITY

Decision Trees

PHYSICAL ABUSE

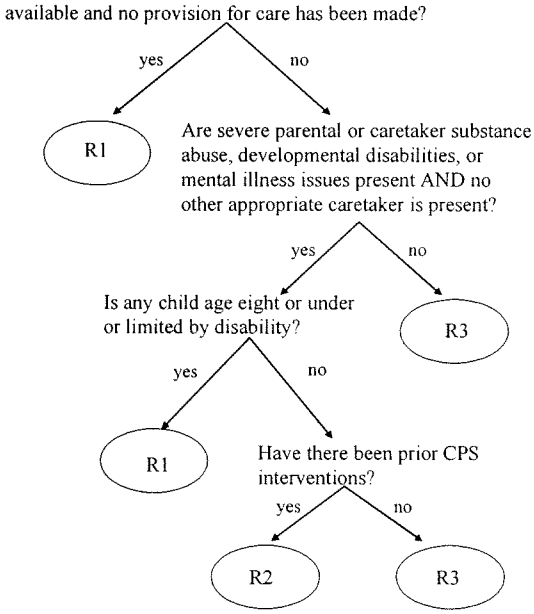


SEXUAL ABUSE



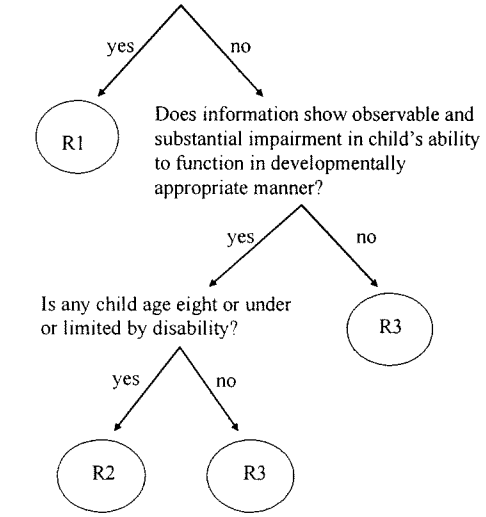
NEGLECT

(Includes medical neglect and abandonment)



MENTAL ABUSE

(Includes exposure to domestic violence)



CHILDREN HOME ALONE

Virginia state statutes do not set a specific age after which a child legally can stay alone. * Age alone is not a very good indicator of a child's maturity level. Some very mature 10-year-olds may be ready for self care while some 15-year-olds may not be ready due to emotional problems or behavioral difficulties.

In determining whether a child is capable of being left alone and whether a parent is providing adequate supervision in latchkey situations, child protective services (CPS) will assess several areas. These areas include:

• **Child's level of maturity.** CPS will want to assess whether the child **is physically capable** of taking care of himself; **is mentally capable** of recognizing and avoiding danger and making sound decisions; **is emotionally ready** to be alone; knows what to do and whom to call if an emergency arises; and has special physical, emotional, or behavioral problems that make it unwise to leave be left alone. **It is important to note that a child who can take care of him/herself may not be ready to care for younger children.**

• **Accessibility of those responsible for the child.** CPS will want to determine the location and proximity of the parents, whether they can be reached by phone and can get home quickly if needed, and whether the child knows the parents' location and how to reach them.

• **The situation.** CPS will want to assess the time of day and length of time the children are left alone; the safety of the home or neighborhood; whether the parents have arranged for nearby adults to be available in case a problem arises; and whether there is a family history of child abuse or neglect.

* Some localities have ordinances concerning the age at which a child may be left without supervision.

June 1, 2002

DISTINGUISHING BETWEEN ACCIDENTAL AND NON-ACCIDENTAL INJURY

One of the most critical responsibilities of child welfare staff during the investigation or review of a child's death is to distinguish between accidental and non-accidental injuries. This is particularly difficult when staff must distinguish between accidents in which chronic neglect or inadequate supervision was a factor and those where neglect is not a concern. In most cases, medical input will be required to make such a determination. These situations include those where the conditions resulting in the child's death appear to be directly created by or under the control of the parent or other person responsible for the child's care, yet the death is not identified as relating to a specific type of maltreatment, as well as those deaths that are alleged or known to have occurred as a result of abuse or neglect. Consideration of the following four factors can provide guidance for this process:

1. Discrepant History. In some cases, the nature of the injury does not match the history given by the parent or other person responsible for the child's care. To determine this requires a detailed description of the incident. What were the circumstances leading up to and following the incident? When did it occur? Who was present at the time of the incident? What was the specific medical assessment of how the injuries occurred and the detailed description of the injuries and the child's condition? What information was obtained during the on-site visit?

2. Delay in Seeking Medical Care. At times, the delay in seeking medical care can range from a few moments to hours. In assessing delay, it is important to realize, for example, that following a severe shaking or beating, the abuser will often place a child down in a crib or on the floor and leave the room. The child may then exhibit symptoms of intracranial pressure (vomiting, seizures and cardio respiratory arrest). These symptoms then cause the person responsible for the abuse to contact emergency help, and that person often disassociates the symptoms from their previous actions.

3. Triggering Event by the Child(ren). This is usually age-specific behavior, such as inconsolable crying, a messy diaper, toilet training problems, etc., which triggers the abuse.

4. A Crisis in the Family. A crisis may have placed additional stress on the family's capacity to cope. Crisis can take the form of unexpected or difficult pregnancy, marital differences, loss of job or death of an extended family member.